

Draft Outline  
For Internal Circulation Only

Department of Health & Family Welfare

Government of Karnataka

Integrated Health, Nutrition &

Family Welfare Services

Development

Initiative in Karnataka

Towards Equity & Quality  
In Health Care Services

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## 1. INTRODUCTION

- The Government and the people of Karnataka have aspirations for a better quality of life and for overall development. Improved health status and better access to good quality health care services is integral to human development.
- The Government of Karnataka through a series of policy measures has attempted, over the years, to create an enabling environment through which this can be achieved. In recent times there has been an acceleration of these efforts.
- The health sector is to be addressed in its totality including public, voluntary and private health care services. This would require an approach covering all systems of medicine and local health care traditions.
- The role of public health and related services is critical in addressing basic determinants of health, in responding to public health problems and in protecting and promoting the health of the poor and of marginalised sections of society. The state also has a role in maintaining standards and in fostering the practice of ethical principles in medical care and public health.
- At the same time, along with the public sector, the private sector also plays an important role in providing medical care to the people.
- To improve the health care systems in the State, the Government of Karnataka set up the Karnataka Task Force on Health & Family Welfare (KTFH) in December 1999. The composition of the 14 member Task Force (13 outside experts and one senior officer) indicates the commitment of the State Government to develop partnerships with different sectors. The Task Force submitted its Interim Report in April 2000. Its final report is expected in a few months time (end 2000, early 2001).
- The Department of Health & Family Welfare, based on the recommendations in the Interim Report, and its own experiences and planning processes, is developing a plan for an integrated health care system. Vertical health programmes and ongoing externally aided projects, such as the KHSDP and IPP VIII and IX, will be sustained and integrated functionally into the health system.
- This paper addresses the identified gaps in the health care systems, public, private and voluntary and provides the conceptual framework for an integrated health care system.



## 2. CONTEXTUAL BACKGROUND OF KARNATAKA STATE:

### 2.1 *Historical Background*

Karnataka State (known till 1973 as Mysore State) was created during the reorganization of States in 1956. It incorporated the erstwhile princely state of Mysore; the northern districts of Bidar, Raichur and Gulbarga from Hyderabad State, previously under the Nizam's rule; Belgaum and Dharwad districts from Bombay Presidency; Dakshina Kannada and Bellary from Madras Presidency; and the autonomous princely state of Kodagu. The Presidencies had been part of British India, while the others were semi-autonomous. The political histories, traditions and administrations of these regions of the new State were very different. These continue to influence later development.

Health services had developed in the different regions in the pre-Independence era. Under the Mysore Maharaja and his visionary Diwans, health services grew within a liberal, welfare-oriented administration, evidenced by establishment of the Krishna Rajendra Hospital in 1876, the College of Indian Medicine (Ayurveda and Unani) in 1908, a medical college (Allopathy) in 1930 (all in Mysore city), besides hospitals in other cities and towns. The first primary health units, serving rural populations in India, were pioneered in the State in the 1920s, the first being established in Ramanagram. Thus, traditions of State runs health services had been established early.

After 1956, the State Government expanded its health care infrastructure on the foundations of the existing health units and hospitals. National health programmes, which were being formulated during this period, were implemented in the State. Guidelines and financial support from the Government of India strengthened the development of rural health services based on population norms.



### Current State Profile:

Table 1 below gives the current profile of the State.

Table 1: State Profile

Variable	Current Status	Comment
Area	191,791 sq.km.	5.38% of the area of the country, approx. equal to Germany
Population (2000 est.)	52 million	Current growth a little less than a million a year, with the rate steadily declining.
Rural-urban population distribution (1991)	69% rural (27,066 revenue villages inclusive of 48,000 habitations), 31% urban in 254 towns/urban areas.	Urban population has increased by 10% over 50 years
Scheduled caste population Scheduled tribe population (1991)	16.4%, Scheduled caste; 4.26%, Scheduled tribe.	This section constituting 20.7% of the population are the most vulnerable economically and also socially most backward.
Literacy rate (1996 est.)	Overall literacy rate - 63.4%. females 52.6%, males 73.7%; rural 47.7%, urban 74.2%.	Large inter-district differentials exist. Dakshina Kannada has a literacy rate of 85%, while Raichur is still at 40%. Total literacy drives since 1990 have achieved major gains in a few districts like Dakshina Kannada and modest improvements in others.
Per capita income (1995-96)	Rs. 7,155 at 1993-94 prices	Range is from Rs 20,120 in Kodagu to Rs 6,223 in Kolar District.
Average District Income (1995-96) at 1993-94 prices.	Rs. 58512 million in Bangalore and Rs. 6416 million in Bidar.	Inter-district variations affect human development.

Source: HDR-GOK, 1999.

Table 2 gives the health status indicators of the State. As is seen Karnataka is ahead of the all-India targets for the year 2000.

Table 2: Health Status Indicators in Karnataka, 1998 - Rural Urban

Indicator	Karnataka (1998-99)	India (1998)	India-Targets for 2000
Crude birth rate	22/1000	25.9	21.0
Crude death rate	7.5/1000	8.7	9.0
Infant mortality rate (per 1000 live births)	52 58 (SRS)	63	<60
Life expectancy at birth			
Male	65.1 years	62.4	64.0
Female	66.3 years	63.4	64.0

Source: 1998-99 Annual Report DII&FWS, GOK, 1998 SRS, NFHS II, 1999



### 2.3 Public and Private Health Services and Access to Care:

Karnataka has developed a widespread network of services since 1951. The progress achieved during the period between 1951-1987 is indicated in Table 3, while the number of institutions existing at present is given in Table 4.

Table 3: Development of Public Sector Health Services in Karnataka, 1951 – 1987.

Health Institutions	1951	1987
Hospitals with above 30 beds	23	134
Teaching Hospitals	0	23
District and Major Hospitals	20	30
Hospital beds	5481	26646
Dispensaries + Primary Health Units	282+125	1310
Primary Health Centres	0	465
Primary Health Units with 6 beds	20	106
X-ray Plants	15	126
Nursing Schools	5	9
Health & Family Planning Training Centres	2	5
Auxiliary Nurse Midwife Training Schools	0	4
Laboratory Technician Training Units	0	4
X-ray Technician Training Units	0	10

Source: GOK 1998-99, Annual Report of DH & FW, SRS, 1998.

Table 4: Public Sector Health Services in Karnataka, 1998

Type of Health Service	Number
Hospitals – district, major (specialised, teaching), maternity *	176
Community Health Centres	252
Primary Health Centres	1676
Urban Primary Health Centres	9
Primary Health Units	583
Subcentres	8143
Public beds (1996)	43868
Private beds (1996)	40900

Source: GOK 1998-99, Annual Report of DH & FW, HDR 1999

\* There are additional specialised hospitals for TB, leprosy, infectious diseases, mental health under the Directorate of Medical Education. Institutions run by municipal corporations in urban areas are not included, as they come under the respective local bodies.

Studies show that over 45% of patients utilizing public sector services in Karnataka had annual incomes below Rs 15,000/-, which is close to the official poverty line, while over 90% had incomes below Rs 50,000/- (World Bank, 1996).



Private sector medical services had a growth spurt during the 1980s. Located primarily in urban areas (80%), they account for 33% of hospital beds (*ibid*). A 1995-96 summary by STEM listed 1709 medical institutions (clinics to hospitals) in Karnataka (HDK 1999). The 1993 NCAER survey reports that 46% of out patients and 40% of inpatients were treated by the private sector (*ibid*.)

A majority of patients using private clinics in Karnataka were found to belong to the middle and upper socio-economic classes (World Bank, 1996). The quality of care in the private sector varies greatly from village and mofussil towns to the big cities (Narayan 1998).

The public sector has the most evenly distributed widespread services, covering all districts and rural areas, and is utilized to a larger extent by the poor. Accessibility and affordability of health care services, particularly for the poor, is one of the cardinal principles of primary health care.

## 2.4 Health Budgets & Expenditure

Nationally 80% of public spending on health is by the State, 20% being from the center. In Karnataka, about 18% of the state health budget comes from the center. According to an analysis by the Department of Health and Family Welfare (KHSDP, June 1999) the expenditure on health related services (which includes medical care, public health, family welfare, water supply & sanitation, housing and nutrition) has grown in real terms at the rate of 7.2 per cent per annum during the period 1990-91 to 1999-2000. However, there has been large variation in different components. The expenditure on nutrition declined in real terms at the rate of 4.3 per cent per annum. In overall terms, government health and family welfare expenditures continues to be low.

According to a study made by the World Bank (1996), the per capita expenditure on Health and Family Welfare has increased in 1980-81 prices from around Rs.19 to Rs. 30 during the period 1980-81 to 1993-94. The Health and Family Welfare budget as a percentage of the State Budget is around 5%.

Table 5: Expenditures on Health and Family Welfare in Karnataka

Category	80/81	85/86	89/90	90/91	91/92	92/93	93/94
Expenditure on H & FW as % of State Domestic Product	1.26	1.33	1.25	1.18	1.11	1.29	1.29
Per Capita expenditure on H & FW (in 1980/81 Rs)	19.00	22.12	26.00	24.12	25.01	27.83	30.20

Source: WB 1996



## 2.5 Externally Aided Projects:

Externally aided projects negotiated since 1994-95 include:

- a) Rs 1508 million for India Population Project IX from World Bank, for development of rural primary health care infrastructure, to strengthen family welfare and MCH services.
- b) Rs 5458 million from the World Bank for the Karnataka Health Systems Development project, (KHSDP) for strengthening secondary care institutions at CHC, Taluk and district levels.
- c) Rs. 591 million from KfW (Germany), for secondary care at district, taluka and CHC level hospitals in Gulbarga division.
- d) Rs 830 million for IPP VIII from World Bank for strengthening Family Welfare & MCH in Bangalore city and 11 other cities.
- e) An OPEC grant of Rs. 292 million for a superspeciality hospital in Raichur.

+ some projects  
2011-12 - 12 projects identified  
Detailed financial survey 1993.

## 3 HEALTH SECTOR ANALYSIS

### 3.1 Strengths of the Health Sector in Karnataka

Strengths of the health sector in the State are:

- i. Health gains made taking health status levels above national average. National Health Policy goals of 1983 were met, e.g.
  - Increased LEB from 26 years in 1947 to 66.3 years (women) and 65.1 years (men) in 1997.
  - CBR declined from 41/1000 from 1951 to 22/1000 (1998)
  - CDR declines from 22/1000 from 1951 to 7.5/1000 (1998)
  - Eradication of small pox & guinea worm infestation.
  - Control to a considerable extent of vaccine preventable diseases, polio, whooping cough, tetanus, diphtheria, and progress is being made to reduce measles disease.
  - Increased Couple Protection Rate from 23.8% in 1981 to 57.7% in 1997 with fairly rapid fertility decline.
- ii. Development by the state of a widespread network of health care institutions at all three levels (primary, secondary, tertiary), even in excess of GOI norms.



- iii. Support to innovations through research institutions – NTP through NTI, community mental health programmes through NIMHANS, bio-environmental control of malaria through MRC.
- iv. State policy support to growth of voluntary and private sector in medical & health care and in health professional education, with some initiatives towards regulation.
- v. Capacity to negotiate & utilize to a fair extent external assistance e.g. KHS DP, IPP VIII and IPP IX.
- vi. Most recently the setting up of the Karnataka Task Force on Health & Family Welfare.
- vii. Fairly active civil society groups and organisations.
- viii. Premier academic and research institutions providing a sound knowledge base.
- ix. Private and voluntary sector involved with a broad range of activities from primary medical and health care, secondary and tertiary care, health professional education, to research and medical informatics.
- x. A project planning policy matrix was developed and is being used. Table 6 on the next page summarises the current position on the important issues identified and the Table shows that action is being taken on the major issues identified.



**Table 6: Summary of the health sector development policy programme in Karnataka**

Issues	Proposed Changes and Action Taken
1. Adequate budget for Public Health. Earlier only 5% of State budget and 1.48% GDP spent on Public Health.	Allocations stepped up progressively. Increased from Rs. 535.49 crores (1996-97) to Rs. 1112.64 crores (2000-2001) Increased from 5.9% to 6.1% of State budget.
2. Imbalances in expenditure on health with more emphasis on tertiary care.	Increased allocation to primary care (43.96%) & secondary care (40.9%) as against only 15.2% to tertiary care.
3. Regional imbalances with six districts Gulbarga, Bidar, Bijapur, Raichur, Dharwad and Bellary having poor health indicators.	Preferential health policy for these districts by increasing funding from state, IPP IX, KfW, OPEC and RCH.
4. Improving quality of hospital services and accessibility by women and SC's/ST's.	<ul style="list-style-type: none"> <li>• Upgradation in 181 hospitals under K.H.S.D.P.</li> <li>• Skill development training for Doctors, nurses and paramedical staff.</li> <li>• Filling up of vacancies by recruitment or on contract basis.</li> <li>• Contracting out non-clinical services.</li> <li>• Yellow card scheme for SC's/ST's</li> <li>• Successful pilot project of Women's Health check-up at Mysore to be replicated in other districts.</li> <li>• No user charges for those below poverty line.</li> </ul>
5. Strategic planning to reduce sub-optimal use of resources.	<ul style="list-style-type: none"> <li>• Strategic planning cell established, published 9 bulletins and brought out booklets for improving health knowledge of Doctors &amp; paramedical staff.</li> <li>• Improvement in hospital waste management</li> <li>• Networking with private health service providers.</li> <li>• Establishment of Task Force w.e.f. 10.11.99 studying all sectors relating to Health &amp; submitted draft Interim Report to Govt. for approval and implementation.</li> </ul>
Private sector and NGO's	<ul style="list-style-type: none"> <li>• Bill for regulating nursing homes and private practitioners introduced.</li> <li>• Licensing of blood banks.</li> <li>• Enlisted NGO's for participation in Task Force, HIV/AIDS prevention and other Govt. Programmes.</li> </ul>
Prevention and control of communicable diseases.	<ul style="list-style-type: none"> <li>• Post of Addl. Director (Communicable diseases) has been filled up.</li> <li>• State surveillance lab at Bangalore has started functioning.</li> <li>• Improvement in district labs.</li> <li>• Manual on case definition, lab techniques and reporting formats (as per WHO guidelines) issued.</li> <li>• Disease surveillance system in advanced stages of development.</li> </ul>



## ***2 Problems & Constraints***

- i. Continuing high levels of poverty with 40% of people below the poverty line. This contributes to and is aggravated by undernutrition, high morbidity, mortality & fertility. These health indicators are still unacceptably high.
- ii. Relative neglect of nutrition in the larger health strategy.
- iii. Inadequate attention through multisectoral linkages to other basic determinants of health namely sanitation, potable water, waste management, education.
- iv. Gender inequities leading to poor women's health status indicators (MMR 4.5/1000, anemia in women, violence against women.)
- v. Other disparities – regional, caste, socio-economic groups, persons with disabilities.
- vi. Neglect of public health principles & practice with inadequate emphasis on promotive, preventive & rehabilitative care, with resultant high burden of TB, malaria, HIV/AIDS, gastrointestinal problems, tobacco related problems.
- vii. Poor quality, unethical practices & poor accountability with corruption in public and private services, leading to patient dissatisfaction & loss of public confidence in services.
- viii. Poor governance & management of public health services.
- ix. Inadequate regulation & facilitation of private sector
- x. Inequitable financing of health services & inefficient financial & infrastructure/asset management.
- xi. Inadequate human resource development and management with poor competencies, low morale & motivation.
- xii. Inadequate community involvement in planning, decision making and feedback at local levels. Relationship with PRIs conflictual. Their potential in public health & primary health care unutilized.
- xiii. Weak strategic planning, inadequate research base;
- xiv. Inadequate integration of externally assisted projects into health system planning



## 4 GOALS

- a) To further improve health status and increase access to health care for people, with an emphasis on the marginalised sectors of society, such as women, children, SC/ST, disabled and the elderly in Karnataka.
- b) To strengthen public health systems and primary health care with community participation, NGO and private sector involvement.
- c) To focus on equity, with quality of services, making explicit efforts to nurture and increase motivation and capacity of health care providers.
- d) To work within a time frame, with regular reviews and transparency in functioning.

## 5 VALUES

The underlying values will be equity, medical and public health ethics, accountability, concern and respect for people, democratic functioning, respect for local health knowledge and culture. These values will form the basis for project planning and implementation. Reviews will consider how much these have been internalized and what difficulties are faced in these aspects.

## 6. GUIDING PRINCIPLES

The guiding principles for implementation will be:

- **Integration** – moving from vertical disease/problem oriented programmes to horizontal integration at primary care level (sub-centre, PHC, Taluka, general hospital) and more specialized referral and support services at district and state level.
- **Phased decentralization** – moving towards district and local planning and management using information from the HMIS. The elected representatives will also need to be sensitized and local bodies made accountable for responding to the health aspirations of the people.
- **Building partnerships** –
  - a) by inter-sectoral linkages between and within departments;
  - b) with NGOs for participation in planning, implementation and evaluation; and.
  - c) with the private sector for participation in state health plans and in referral services, and, provision of secondary and tertiary level care.
  - d) With peoples' organizations by providing access to information and encouraging feedback.
- **Social inclusiveness** – particularly of socially excluded groups and their involvement in all levels of care.
- **Community participation** – leading to the empowerment of the local community.
- **Gender sensitivity** across all levels of care.



## 7. OBJECTIVES

The general objectives for a six-year period (2001-2007) are outlined below. Indicators will be developed regarding achievement of objectives. The Logical Framework Analysis will be used for identifying means, resources, activities, persons responsible and time frames.

Problems are deeply embedded in social structures, therefore the choice of objectives is based on needs, feasibility of a health sector intervention, likelihood of making an impact and cost effectiveness, given the resource availability.

The objectives are broadly grouped under three categories, namely,

### 1. Public Health & Primary Health Care

2. Health System Issues – Management, Capacity Building, Finance, Institutional strengthening.

3. Partnerships – with private sector, NGOs, PRIs, local community and other sectors/departments.

### 7.1 Public Health & Primary Health Care

7.1.1 a) *Improve quality, effectiveness and coverage of primary health care.* Ensure access to care at all levels for the poor and under-served.

b) *Strengthen the referral linkages with Secondary Health Care Services.* and fill up gaps, especially in Gulbarga division.

7.1.2 *Improve nutritional levels,* particularly of children (focussing on under two's), adolescents and women, by reduction of undernutrition and nutritional deficiencies, such as Vit. A, Iron and Iodine.

7.1.3 *Improve health of school age going children and adolescents* through a mix of medical, health promotional and educational efforts.

7.1.4 *Health Promotion & Empowerment,* particularly of women and young people through sharing of information and health promotion activities enabling people to make healthier choices and to demand better health and nutrition services.

7.1.5 *Reduce Morbidity & Mortality resulting from priority public health problems.* A public health approach will be used to reduce unnecessary



suffering from TB, Malaria, HIV/AIDS, water borne diseases, disability etc. Priority will also be on decreasing infant, under-five and maternal mortality. Deaths due to accidents and violence (especially unnatural deaths of women) will also need attention. Measures for health promotion, prevention, early detection and cure, and rehabilitation to reduce the suffering and burden of diseases will be taken and encouraged by all health sectors.

- 7.1.6 *Increase services for neglected & emerging health problems*, namely, Mental health, care of the elderly, tobacco related problems, accidents, violence, particularly against women, and non-communicable diseases such as cancer, and, heart diseases.
- 7.1.7 *Develop and sustain a comprehensive Health Information System including health surveillance.*
- 7.1.8 *Redress Regional Imbalances & Disparities.* Actively work to reduce regional imbalances with specific attention to Gulbarga division.
- 7.1.9 *Improve health of scheduled castes and tribes and those below the poverty line.*
- 7.1.10 *Strengthen Urban Primary Health Care Services*, especially in smaller cities, towns and regions.
- 7.1.11 *Improve women's health*
- 7.1.12 *Enhance further fertility decline by provision of reproductive health care through well functioning and credible general health services and by an educational approach.* Focus on districts with continued high fertility rates, with emphasis on child growth and child survival, on overall women's health and women's empowerment. Avoid distortion of health services by excessive emphasis on a programme like sterilization of women.



## 7.2 Health Systems Issues – Management, Capacity Building, Finance and Institutional Strengthening

- 7.2.1 *Develop strategies for human resource development* that focus on capacity building, continuing education, motivation and morale of health teams at all levels. Encourage research and academic work.
- 7.2.2 *Improve the planning, organization, management and administration of the public health systems*, to cover management capacities, personnel management, strategic planning and evaluation, asset management, management of supply lines for equipment, drugs and other consumables, as well as information and communication systems. Decentralised mechanisms to be evolved/ reviewed. Introduce cadre development and management systems.
- 7.2.3 *Develop decentralised district level planning.*
- 7.2.4 *Improve equity and efficiency in health financing and financial management* maintaining a balance between primary, secondary and tertiary care, and between urban and rural based institutions. Safeguard and improve the health budget and ensure adequate utilization with accountable and transparent systems.
- 7.2.5 *Focus on implementation factors and processes* by building competence and morale of field staff, developing leadership abilities from PHC to State level, and having regular public and social audits to safeguard against non-action.

## 7.3 Partnerships - with private sector, NGOs, PRIs, local community and other sectors/departments.

- 7.3.1 Develop specific functioning mechanisms at local district and state levels for better *intersectoral coordination*.
- 7.3.2 *Strengthen capacity of Panchayati Raj and Nagarpalika Institutions* for greater responsibilities and roles in health and health care.
- 7.3.3 *Evolve mechanisms for involvement of the private sector* at different levels with quality assurance. Work actively with the NGO/voluntary sector.
- 7.3.4 *Promote and support Indian and other systems of medicine and local health traditions.*



## 8 EXPECTED OUTCOMES

### 8.1 *Quantitative Indicators of improved health and nutrition status:*

Table 7: Specific goals to be achieved over the next six years:

1.	Life expectancy at birth in years	71 for women, 70 for men
2.	Crude birth rate	17/1000
3.	Crude death rate	7/1000
4.	Infant mortality rate	25/1000
5.	Under - five mortality rate	< 35/1000
6.	Maternal mortality rate	< 199/100,000 live births
7.	Nutrition status of children	Progressive improvement Planned
	Severe undernutrition	< 0.5%
	Moderate undernutrition	10%
	Mild undernutrition	60%
	Normal	> 30%
8.	Anaemia among women	<20%
9.	Anaemia among children	<40%
10.	Newborns with low birth weight < 2500 gms	10%
11.	Immunisation coverage with maintenance of cold chain	> 95%
12.	Safe deliveries with access to Emergency Obstetric Care	> 85%
13.	Case detection and cure rates in TB	75% and 85% respectively
14.	Specific health programmes (HIV/AIDS, malaria, blindness, etc.)	as per programme guidelines, accelerated.

8.2 *Qualitative Indicators:* External cum internal reviews will be conducted using qualitative research methods. These reviews, among other things, will focus on:

1. Mechanisms for community involvement at local, district and State level. Participation of all sections of society.
2. Linkages with Gram Panchayats and Zilla Parishads.
3. People's feedback and perspectives on functioning of PHCs, CHCs, Taluk General Hospitals, District Hospitals and other health services. This would include staff attitudes, payment systems and quality of care. Feedback to be inclusive -- from women / SC/ST / poor / differently abled/ elder persons.
4. Gender perspectives -- availability of privacy, toilets, harassment, recording of violence, gender disaggregated data.
5. Functioning of referral system.
6. Prescription audits.
7. Budgetary and infrastructural support to ISMs/ other systems. Their involvement in programme planning.



8. Planning processes, coordination and communication mechanisms, reviews and mid-course changes/ modifications in programmes, identification of learning points.
9. Reduction in regional disparities.
10. Analysis of expenditure by the three levels and urban- rural distribution.
11. Feedback from Government health personnel from all levels regarding working conditions, job satisfaction, continuing education, feeling of self worth.

### 8.3 *Health System Indicators:*

Staff positioning.

Condition of infrastructure through the GIS.

Supply systems for drugs, laboratory, reagents, and other consumables.

Transport – vehicles, drivers, POL.

Communication systems.

Utilisation of health services - outpatient and inpatient

Hospital Institutional morbidity, case fatality.

Management indicators.

### 8.4 *Indicators for Equity & Quality:*

Equity and quality indicators are critical and will need to be developed through a participatory method involving the stakeholders.

## 9 BROAD STRATEGIES

Develop a comprehensive Karnataka State Health Policy.

Update the Karnataka Public Health Act on the model of Public Health Act circulated by the Government of India in 1987.

Put in place an Act for private sector accreditation to ensure quality, ethics and standards of care among private sector health providers.

Use an evidence based and dialectical approach in the development and modifications of policies and plans. This will allow for constant learning from difficulties faced.

Move towards decentralized planning, management and monitoring cum reviews at the District level, within a framework and guidelines developed at the State level.

Allow for flexibility, creativity and local innovations/ initiatives in responding to health problems at the local level, but also ensuring accountability and responsibility.

Develop and nurture leadership and a critical mass of public health specialists and managers at all levels.

Use private health care specialists and professionals in the Health care system.

The fundamental thrust will be on capacity building at all levels, in all sectors.



## 10. SPECIFIC STRATEGIES

These will be developed further using a consultative, participatory and evidence based approach.

### 10.1 Public Health and Primary Health Care

*10.1.1 Access, quality & effectiveness of Primary Health Care Services* will be improved by,

- a) Filling in gaps in physical infrastructure for primary health centre and subcentres, including construction of quarters and undertaking renovation and maintenance where required. This would include provision of water supply, electricity and basic equipment and consumables required for diagnostic and therapeutic work. Findings of the facility survey being undertaken will be validated and used for cost estimation of requirements.
- b) Filling up of gaps in health manpower by sanctioning / creating of required / additional posts in the existing / newly created health centers as per norms.
- c) Selective upgrading of PHCs into FRUs and CHCs according to current norms, in Gulbarga division and other backward pockets of the State.
- d) A well planned referral system that functions both ways to be implemented in a district and then expanded. Gaps in the existing secondary health care services to be filled up.
- e) Steps to improve quality of services provided by the private sector through accreditations/ guidelines will be implemented.
- f) Put in place a system for outcome and financial audit of primary health care institutions.
- g) Ethics training.

### *10.1.2 Nutrition:*

Good nutrition is an entitlement (Amartya Sen), with the need for adequate income or purchasing power. Nutrition is a basic determinant of health, has been grossly neglected by the health sector in Karnataka so far. Recent data from NFHS II and NNMB provides evidence of a high level of under nutrition in Karnataka. Therefore nutrition is taken up as a priority with specific interventions by the health sector, and with intersectoral linkages with the Departments of Women and Child Development, Food & Civil Supplies, Agriculture, Rural Development & Panchayati Raj & Education. The health system needs to be accountable for the poor nutritional status of the population.

*Child Nutrition:* particularly of under-tuos, from the period of conception, will be given the highest priority. Strategic action points include:

- a. Closer collaborative mechanisms between health, WCD (Women and Child Department) and Panchayats particularly at the local level in the functioning of Anganwadis (AWs).
- b. Universalize AW centres for every 1000 population in rural areas and 1500 in urban areas. Priority will be given to Gulbarga division. Valuable lessons learnt



from the TINP programme of Tamilnadu will be studied and used where appropriate.

- c. Vacancies of Anganwadi Supervisors to be filled urgently (currently there are approx. 660 in position out of 2000 posts to cover the existing 40,000 Anganwadis) and these supervisors will be provided refresher training.
- d. As far as possible women to be appointed as CDPOs. Gender sensitization at all levels.
- e. Persons with nutrition training and experience to be positioned at senior levels at state and district levels both in the Health & FW and W&CD departments.
- f. Gram Panchayats to be involved more closely and decentralization monitored to ensure that the poor have access and benefit optimally.
- g. The strategies for under two children include mothers' education and supplementary feeding in areas of need, especially in Gulbarga division.
- h. *Micronutrients* iron supplementation for children, adolescent girls, women and men when required, regular deworming, Vit. A supplementation and Iodine where required.
- i. *Education regarding nutrition* at all levels of the health, WCD and education systems. Nutrition education to be seen as part of health promotion.

#### 10.1.3 Improving health for school age children and adolescents

A blue print for a programme for improving health for school age children that includes out of school children. (The existing programme does not cover school dropouts. This will include: *and men*

- ◆ Physical *and men* health – health cards for children, including medical checkups and follow-up treatment *and men*
- ◆ Health preventive and promotive education and activities. This would involve:
  - teacher training – in teacher training schools and through in-service programmes,
  - development of modules, manuals for teachers development of educational material for children, building on what already exists.
  - use of child to child methods to reach out of school children
  - adolescent health education

This shift in emphasis will require close collaboration between the departments of Health and Education. This effort will be tested and phased in different districts.

#### 10.1.4 Health Promotion & Empowerment

- a) This will include training of leaders of women's groups, from Mahila Samakhya, agricultural women's Sanghas, DWCRA, NGO women's groups, self-help groups, etc.
- b) Training of youth groups, opinion leaders, etc.
- c) Reaching out to the marginalized and unreached sections of the population using different methods of communication from interpersonal modes, and mass communication modes.



- d) Launching of a comprehensive and coordinated IEC campaign covering all sectors and levels of the Health System. To the extent possible, the campaign will focus on local area specific problems and issues.

#### 10.1.5 *Reduction in Morbidity and Mortality*

The system will be strengthened for control of public health problems (TB, Malaria, HIV/AIDS etc.) through integration at primary care level, with specialized referral and technical support at secondary/tertiary levels. Provisions will be made to fill in gaps in the existing system and for response to sudden needs, including outbreaks.

#### 10.1.6 *Increased services for neglected and emerging health problems.*

- a) *Mental Health Care* - This is an orphan subject with very limited resource provisions in Karnataka. Research studies in the State show that at least 2% of the population suffer from severe mental morbidity, and at least 10% from neurotic conditions, alcohol & drug addition & personality problems. While mental health care needs to be provided at PHC level in the long term, during the next 5 years it is necessary to

- i. Improve training in psychiatry & psychology in the MBBS course & in general nursing training.
- ii. Strengthen psychiatric and counseling services at district hospital level and subsequently at Taluk Hospital.
- iii. Organize training programmes for PHC – MO's and staff using manuals prepared by NIMHANS. Ensure provision of psychiatric and epileptic drugs.
- iv. Encourage/make provision for care/ facilities for chronically mentally ill persons, as in the present context family members are unable to do so.
- v. Develop working links with NGOs, traditional healers, religious organisations, etc.

- b) *Care of the elderly* – Developing geriatric services/units in secondary and tertiary care institutions; developing training programmes for health personnel with the Health University; providing support to developing long term, home based programmes.

- c) *Tobacco* and substance abuse programmes – support to public education and advocacy programmes and to tobacco quitting.

- d) *Accidents* – support to research, legal measures, trauma centres and rehabilitation. Intersectoral coordination with dealing in transport, industry, roads and highways.

- e) *Violence* – training programmes for health professionals for recognition of the problem, introducing recording and reporting systems, support to care homes and rehabilitation centres. Violence against women to be specially addressed.

- f) *Other non-communicable diseases* – Non-communicable diseases such as cancer, diabetes and heart diseases, etc. will be addressed.



#### 10.1.7 *Health Information System:*

Processes are already under way to rationalize recording and reporting systems from primary care levels upward, to develop comprehensive HMIS and GIS and a disease surveillance system. Support for development, maintenance, technical manpower and upgrading of the system will be required.

#### 10.1.8 *Reduction in Regional disparities*

Specific efforts will be made to reduce *Regional disparities* by strengthening infrastructure, personnel and educational inputs. This will cut across most strategies.

#### 10.1.9 *Improve health of SC/ST and others below the poverty line*

The initiative taken under KHS DP with the Yellow Card scheme needs to be sustained and deepened to include follow up, health promotion and full curative services. This programme will be expanded to cover all families below the poverty line as it has been an acknowledged effort at providing health care interventions for certain vulnerable sections of the society. Special effort will be made for improving health care for tribal families, especially with the help of NGOs.

#### 10.1.10 *Strengthening Urban Health Care Services*

Due to historical reasons, urban health care services are administratively under the respective local municipal bodies. This is also mandated by the 74<sup>th</sup> Amendment of the Constitution. The large number of teaching, tertiary & specialist hospitals in urban areas come under the administrative purview of the Dept. of Medical Education. The private sector too has a large presence (80%) in urban areas with a range of services from corporate super-specialty hospitals and diagnostic centres to individual private practitioners. Most of the above institutions are providers of curative care.

There is an urgent need to strengthen public health interventions and provide primary health care services, particularly for the urban poor. The following steps are envisaged-

- a) Support to Public health measures for provision of safe water, sanitation, solid waste disposal, and hospital waste disposal. This will include support to testing of water quality.
- b) Existing municipal corporation dispensaries and IPP VIII centres to expand the scope of their work to cover primary health care. Add new urban primary health centres where necessary, especially in small towns.
- c) Involvement of local communities through link workers, health committees, boards of visitors.
- d) Involvement of NGOs in primary care, community mobilization, rehabilitation and in areas of their expertise evolving methods of financing, using their knowledge base, professional and managerial skills.



- e) Developing referral links with private sector institutions evolving methods of financing, using their knowledge base, professional and managerial skills.

#### *10.1.11 Improve Women's Health*

Women's health status will be improved by:

- a) gender and social sensitivity training for all staff
- b) positioning of women medical officers at PHC's where possible
- b) empowerment training for women leaders and communities
- d) increased access to care and improved reporting of women's health problems

#### *10.1.12 Fertility Decline:*

It is recognized that the best strategy for population stabilization is through improved health and nutrition status.

- a) The burden of contraception so far has been on women. Participation of men will be increased through community education and provision of facilities and expertise for men's sterilization.
- b) In districts with high TFR, especially in Gulbarga Division, women's literacy rates, utilization of antenatal care and childhood immunization rates are poor. Additional inputs and efforts will redress these disparities by improving service delivery to meet unmet needs.
- c) Quality of contraceptive services will be ensured to minimize side effects. Systems to monitor complication and adverse reactions will be initiated. Only safe contraceptive technology will be used.
- d) Increase in the age at marriage and postponement of the first pregnancy will be a key strategy.
- e) Compulsory registration of births and marriages will be attempted.

### **10.2 Health System Issues – Management, Capacity Building, Finance and Institutional Strengthening**

#### *10.2.1 Human Resource Development*

This forms the core thrust of this project, and is critical coming as it does along a period of infrastructure development. Orientation courses, in-service training, continuing education and skill development will be part of the efforts to make the DH & FW a learning organisation. Steps to be taken will include:

- a) Developing working links with the Rajiv Gandhi University of Health Sciences with medical colleges, nursing schools and other allied health science educational institutions for training. Medical colleges to take charge of 3 PHCs and associated sub-centres.
- b) Full support to the State Institute of Health & Family Welfare to become a premier training institution in public health, health management & administration, medical and public health ethics.



- c) Orientation and in-service training for PHC Medical officers ANMs, Junior Health Assistants Females, and male, laboratory technicians, lady health visitors & nurses. PHC team training could be considered and undertaken at taluk / district level.
- d) Private sector professionals and institutions to be involved in training, and skills development..

#### 10.2.2 *Management Development*

- a) Strengthen management capacity at all levels through training
- b) Introduce non medical health managers and hospital administrators
- c) Health cadre planning & management to be systematically undertaken
- d) Drug equipment procurement and supplies systems to be modernized and made transparent with development of district stores.
- e) Critical issues of morale and motivation of government health personnel to be addressed, using a research based approach to see what works. Decentralized small working units with independent decision making powers to be tried.
- f) Strategic planning & evaluation cell to be given high priority and adequate infrastructure

#### 10.2.3 *Develop capacity for decentralised district level planning by*

- a) Developing district epidemiological units, of which the surveillance and HMIS units are a part.
- b) Microplanning exercises at T.Narsipur Taluk to be studied and further developed / expanded.

### 10.3 *Partnerships*

#### 10.3.1 *Intersectoral co-ordination*

This will be actively attempted with Dept. of Women & Child Development, Education, Rural Development and Panchayat Raj, Water Supply & Sewerage Boards. PDS agriculture, Social Welfare Board etc at the state, district and primary care level. These are required for

- a) Monitoring water quality, improving sanitation and waste management
- b) Nutrition, school health, rehabilitation, links with PRIs etc.

#### 10.3.2 *Empowerment of members of Panchayati Raj Institutions and Nagarpalikas for Health*

Panchayati Raj institutions (PRIs) are mandated constitutionally to form part of governance structures for primary health care and public health. To enable and equip members to play an effective role, empowerment training of newly elected representatives of PRIs for health, will be conducted by the DHFW in collaboration with others.



Current numbers of elected representatives are as follows: —

Table 8: Elected representatives in Karnataka (July 2000)

Elected Body	Female		Male	
	No.	%	No.	%
Gram Panchayat Members	35,187	44.85	43,273	55.15
Taluk Panchayat Members	601	15.25	3,340	84.75
Zilla Parishad Members	339	26.94	919	73.06
Total	36,127	43.14	47,532	56.86

These 78,460 elected gram Panchayat members commenced their five-year term in April 2000 and the 5,199 Taluk Panchayat & Zilla Parishat members assumed office on 1<sup>st</sup> July 2000. Training programmes on health conducted by the DH&FW will be refined and undertaken with the cooperation of NGO's, health science training institutions and other academic bodies. Women Panchayat members, especially at Gram Panchayat level, have a greater interest in health and will be selected first for training.

Training programme content will cover priority health problems, existing government health services and programmes and how to access them, health promotion messages, utilisation of local health traditions, when to refer etc. Kannada manuals have already been developed for the Women's Health Empowerment Training Programme at two levels for Training of Trainers and for Community Leaders. Other existing material in Kannada developed for the RCH, IPP VIII and other programmes could also be used. Training could be at two levels, namely, 'Training of Trainers' for district level teams, followed by training of GP members at sub-district level. The entire state could be covered over a period of 1 year.

#### 10.3.4 Partnerships with the private sector, with NGO's and health professional bodies.

This important strategy aims to increase access to health care to involve all sectors in state health plans and programmes; to bring in specialists and academics from the private sector to support implementation training, and research; and to increase quality of care. Strategies include:

- Working links will be established or furthered with representative bodies such as the Indian Medical Association, Indian Association of General Practitioners (IAGP) Confederation of Indian Industries, FICCI, Federation of Obstetric & Gynecologic Societies of India (FOGSI), Associations of Surgeons, Pediatricians, Physicians, Ophthalmologists etc, with the Voluntary Health Association of Karnataka, FEVORD-K, AIDS Forum Karnataka, CHAIKA, and other bodies. This should provide additional professional and financial support to programmes.
- A deeper study /cluster of studies of the private sector to understand its distribution, the type of work done, the strengths and weaknesses.



- c) Quality assurance through the Accreditation Act, and the Consumer Protection Act.
- d) Provision of referral services at FRUs for emergency and other obstetric & gynecological care through FOGSI members, to be introduced first in Bellary district and then in a phased manner.
- e) Involvement of the private sector in non-clinical services such as transport, cleaning, equipment and asset maintenance, etc.
- f) Pilot trialling of health insurance system for the poor in selected areas, with involvement of private health institutions.
- g) Involvement of medical colleges through the ROME scheme (Reorientation of Medical Education) to run 3 PHCs & associated subcentres, with administrative control & freedom in staff appointment. This will require upgradation of buildings, equipment, transport, communication & HMIS systems to promote best practices as part of teaching/ academic institutions. Of the 23 medical colleges in Karnataka, 19 are private. Totally 69 PHCs would get covered in the state under this programme. This will assist colleges in meeting Medical Council of India & University requirements. It will also help develop / strengthen links between universities and health services. This strategy could potentially allow for involvement of state health service personnel in the training of medical undergraduates, which will have mutual benefits.
- h) A body of experts drawn from relevant areas in the private/NGO sector to be considered for supporting the department's public health efforts.

#### 10.3.5 *Promote and support Indian Systems of Medicine and Homeopathy (ISM & H) by the following measures:*

- a. Progressive increase of budgetary allocation from the present level, which is less than 1% of the State health budget.
- b. Involvement in planning processes and in service delivery by posting ayurvedic/ homeopathic physicians as Medical Officers in ISM & H units that will be established at District Hospitals and subsequently at taluk Hospital levels.
- c. Support to education & research institutions for ISM & H.

### 10.4 Project Management

#### 10.4.1 *Project Monitoring Information System*

To ensure all the project objectives are achieved project input as well as outcome indicators will be developed before the commencement of the project and woven into a comprehensive PMIS. This will include financial monitoring as well monitoring of physical benchmarks.



#### *10.4.2 Project Implementation and Steering Committees*

Structures designed in the context of the KHSDP have been found effective. Similar structures with appropriate modifications, as well as additional review structures at the Directorate and district levels will be set up.

#### *10.4.3 Supervision and inspections*

To ensure quality as well as speed of implementation, supervision and inspection mechanisms involving external agencies, consultants as well as the Health administration will be put in place.

#### *10.4.4 Consultancies, studies, fellowships and workshops*

Project implementation and capacity building will be supported throughout the project with consultancies, research studies, workshops and fellowships.



**Tentative Costing for the Integrated Health, Nutrition and Family Welfare Services Development Initiative in Karnataka : 2001-2006 (by Strategies)(figs. in rs. crore)**

Sl. No.	Project Strategies	Investment costs	Recurrent costs	Total costs
<b>1.</b>	<b>Public Health and Primary Health Care</b>			
1.1	Access, quality & effectiveness of primary health care services.	200.00	50.00	250.00
1.2	Improving nutrition levels.	30.00	40.00	70.00
1.3	Improving health for school age going children and adolescents.	10.00	10.00	20.00
1.4	Health promotion and empowerment.	10.00	10.00	20.00
1.5	Reduction in morbidity and mortality.	10.00	30.00	40.00
1.6	Increased services for neglected and emerging health problems.	10.00	10.00	20.00
1.7	Health information system.	10.00	10.00	20.00
1.8	Reduction in regional disparities.	10.00	30.00	40.00
1.9	Improve health of SC/ST and the poor.	20.00	10.00	30.00
1.10	Strengthening urban health care services.	30.00	20.00	50.00
1.11	Improving women's health.	0.00	10.00	10.00
1.12	Fertility decline.	10.00	10.00	20.00
<b>2.</b>	<b>Health system issues, training and management</b>			
2.1	Human resource development.	10.00	30.00	50.00
2.2	Management development.	10.00	10.00	20.00
2.3	Decentralised planning	10.00	0.00	10.00
<b>3.</b>	<b>Partnerships</b>			
3.1	Intersectoral collaboration.	10.00	0.00	10.00
3.2	Empowerment of members of PRIs and Nagarpalikas.	10.00	0.00	10.00
3.3	Partnerships with private and NGO sector.	10.00	0.00	10.00
3.4	Promoting and supporting Indian systems of medicine and homeopathy.	10.00	10.00	20.00
<b>4.</b>	<b>Project management</b>			
4.1	Project monitoring and supervision	10.00	0.00	10.00
4.2	Consultancy, studies and fellowships	20.00	0.00	10.00
	<b>Total Base Cost</b>	<b>450.00</b>	<b>290.00</b>	<b>740.00</b>
<b>5.</b>	<b>Price and physical contingencies</b>			
5.1	Physical contingencies	30.00	0.00	30.00
5.2	Price contingencies	20.00	10.00	30.00
	<b>Project Total</b>	<b>500.00</b>	<b>300.00</b>	<b>800.00</b>



**Tentative Costing for the Integrated Health, Nutrition and Family Welfare Services  
Development Initiative in Karnataka : 2001-2006 (by Components)**

(figs. in rs. crore)

Sl. No.	Project Components	Base costs
<b>1.</b>	<b>Investment Costs</b>	
1.1	Civil Works (Renovation)	150.00
1.2	Civil Works (Extension)	80.00
1.3	Professional services	20.00
1.4	Furniture	50.00
1.5	Equipment	20.00
1.6	Vehicles	10.00
1.7	Medicines	40.00
1.8	Other supplies	20.00
1.9	MIS materials	10.00
1.10	IEC and health promotion materials	10.00
1.11	Local training	10.00
1.12	Local consultants	10.00
1.13	Fellowships	10.00
1.14	Workshops	10.00
	<b>Total investment costs</b>	<b>450.00</b>
<b>2.</b>	<b>Recurrent Costs</b>	
2.1	Salaries of additional staff	160.00
2.2	Operational expenses	60.00
2.3	Building maintenance	40.00
2.4	Equipment maintenance	30.00
	<b>Total recurrent costs</b>	<b>290.00</b>
	<b>Total BASELINE COSTS</b>	
	Physical contingencies	30.00
	Price contingencies	30.00
	<b>Total PROJECT COSTS</b>	<b>800.00</b>

